Arizona Health Care Cost Containment System
Arizona Department of Health Services Division of
Behavioral Health Services
Report for Contract Year 2007

External Quality Review
Annual Report

Submitted by:
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EXECUTIVE SUMMARY

A. Introduction

The Federal Balanced Budget Act of 1997 (BBA) mandated that states ensure the delivery of quality health care by all their Medicaid managed care contractors, in part, by participating in an external quality review (EQR) process.[1] The BBA specified three mandatory EQR activities, including monitoring compliance with federal managed care regulations, validation of performance measures, and validation of one or more performance improvement projects (PIPs). The Centers for Medicare & Medicaid Services (CMS) subsequently published protocols for conducting the mandatory EQR activities as well as several optional activities.[2] The EQR component activities must adhere to or be consistent with the CMS protocols and may be completed by one or more entities. A single external quality review organization (EQRO) must prepare the annual report for submission through the State Medicaid Agency to CMS. CMS requires an EQRO Annual Report for each state contracted Medicaid Managed Care Organizations (MCO) and Medicaid Prepaid Inpatient Health Plans (PIHP).

The Arizona Health Care Cost Containment System (AHCCCS) administers the Arizona Medicaid program established under Title XIX of the Social Security Act. AHCCCS contracts with the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) for the delivery of behavioral health services to its acute care members. AHCCCS has an administrative oversight role for all Medicaid services in Arizona. The AHCCCS contract with ADHS/DBHS stipulates the standards for access, structure and operations, and quality measurement and improvement for behavioral health services (BHS). ADHS/DBHS subcontracts with Regional Behavioral Health Authorities (RBHAs) to either provide behavioral health services directly or to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health services to Medicaid-eligible members within their contracted geographic service area (GSA). ADHS/DBHS has Intergovernmental Agreements for Tribal RBHAs (TRBHAs) with some of Arizona's American Indian Tribes for provision of behavioral health services to persons living on the reservations.

B. Summary of the External Quality Review Process, Activities, and Major Findings

The external review process focused on the ADHS/DBHS role as a PIHP, rather than a review of individual T/RBHA's performance. AHCCCS monitors and evaluates ADHS/DBHS compliance with state and federal regulations through an annual Operational and Financial Review (OFR), program-specific performance measures, performance improvement projects, and review and analysis of periodic reports required by the contract. In compliance with the 1997 BBA, AHCCCS contracted with an External Quality Review Organization (EQRO), HCE QualityQuest (QQ), to draft the report of the AHCCCS findings related to quality monitoring of the behavioral health services system. AHCCCS selected the performance measures and PIP for validation by the EQRO, and AHCCCS performed the required monitoring of ADHS/DBHS compliance with federal and state laws regarding managed care systems through its annual OFR. The EQRO has incorporated all three of these required elements into this annual report for Contract Year Ending 2007 (CYE 2007), July 1, 2006 through June 30, 2007.

The Operational and Financial Review tool used by AHCCCS for reviewing ADHS/DBHS contained 134 standards/substandards from eight program areas including General Administration, Delivery System, Recipient Services, Quality Management, Utilization Management, Finance, Appeals and Disputes, and Encounters. Findings were documented for each standard/substandard and a compliance rating assigned.

For the CYE 2007 OFR, ADHS/DBHS was rated in Full or Substantial Compliance for 101 (75%) of the 134 standards/substandards. Seven (5%) substandards received a Substantial Compliance rating, and five (4%) received a Partial Compliance rating. Noncompliance ratings were given in 21 (16%) instances. There were 65 OFR recommendations, and AHCCCS required ADHS/DBHS to submit Corrective Action Plans (CAPs) for 33 (24.6%) of the 134 standards/substandards.

The two Access to Care/Appointment Availability performance measures selected for EQRO validation were routinely monitored by ADHS/DBHS throughout the year and reported to AHCCCS through Quarterly Contractor Performance Improvement Activity Reports. The first of these measures was the extent to which routine assessment appointments were scheduled within seven days or less of referral or request for behavioral health services, and the second of these measures was the percentage of clients that received a behavioral health service within 23 days of initial assessment. In its contract with ADHS/DBHS, AHCCCS established three levels of achievement pertaining to required performance measures. For each of the two Access to Care/Appointment Availability measures, the CYE 2007 Minimum Performance Standard was 85%, the Goal was 90%, and the Benchmark was 95%.

ADHS/DBHS reported that 95.8% of routine assessment appointments were scheduled within seven days of referral statewide from July 1, 2006 through June 30, 2007, exceeding the Benchmark standard of performance. The ADHS/DBHS statewide compliance percentages from quarter-to-quarter ranged from 94.6% to 97.1%. The EQRO repeated these calculations as a part of performance measure validation, also computing the seven day standard as having been achieved 95.8% of the time for CYE 2007. The EQRO-calculated quarterly percentages ranged from 94.7% to 97.0%, in each case being extremely similar to the ADHS/DBHS reported figures.

Combined ADHS/DBHS data for the Gila River and Pascua Yaqui Tribal RBHAs from July 1, 2006 through June 30, 2007 indicated that 87.1% of routine assessment appointments were scheduled within seven days of referral, which exceeded the Minimum Performance Standard for this measure. According to the ADHS/DBHS quarterly reports, the T/RBHAs performance on the seven day standard improved over the year, starting at 70.6% in the first quarter, 93.4% in the second quarter, 91.8% in the third quarter, and 97.2% in the fourth quarter. The EQRO-calculated results differed slightly, but in no instance varied more than 5%, from these ADHS/DBHS results. The EQRO calculations found 87.1% of T/RBHA routine assessment appointments were scheduled within seven days of initial assessment, with percentages of 69.2% for the first quarter, 91.8% for the second quarter, 97.3% for the third quarter, and 97.8% for the fourth quarter.

ADHS/DBHS reported aggregated statewide data for CYE 2007 on the Access to Care performance measure of clients that received a behavioral health service within 23 days of initial assessment. Of the 74.04% of enrollments usable for calculation of this measure, 87.91% of the total statewide usable cases received behavioral health services within 23 days of initial assessment, exceeding the minimum performance standard of 85%. When the total usable cases were divided into child and adult population groups, 89.80% of adults and 84.75% of children received behavioral health services within 23 days of initial assessment. EQRO validation of these data resulted in the same or similar results, in no case differing by more than 5% when compared to the ADHS/DBHS reported data.

The Performance Improvement Project chosen for validation was Psychotropic Medication Polypharmacy. The PIP goal was to promote the use of rational polypharmacy while reducing unnecessary and inappropriate use of multiple psychotropic medications. It was noted that prescribing more than two psychotropic medications (i.e., three or more) within the same class (intra-class) at the same time without specific rationale, other than for cross-tapering purposes, was inappropriate. Also deemed inappropriate was the use of more than three psychotropic medications (i.e., four or more) from different classes at the same time without a specific rationale for the combination. The study question was whether educational efforts targeted toward prescribing clinicians would result in an increase in the appropriate use of polypharmacy as measured by the number of medical records that contain rationale for its use. Calendar year 2005 was the baseline measurement period, and the intervention consisted of distributing a Polypharmacy Technical Assistance Document delineating the appropriate and inappropriate use of multiple psychotropic drugs for a single individual within a specified period of time. AHCCCS identified numerous design and measurement issues with the PIP that did not appear to have been addressed, resulting in a low ability to draw credible conclusions about the scope of the problem or the effectiveness of the intervention.

C. Conclusions and Recommendations for ADHS/DBHS Related to Timeliness, Access, and Quality of Behavioral Health Services

Timeliness and access are important features of the process of care, but quality of care is best measured through changes in treatment outcomes such as health status, functional status, or enrollee satisfaction, or valid proxies of these outcomes. A major standard in the CYE 2007 OFR determined that there was evidence of positive clinical outcomes for behavioral health recipients receiving behavioral health services. ADHS/DBHS achieved the statewide contractual performance standard of 80% of recipients reviewed through the multiple measures analyzed through the Independent Case Review (ICR) demonstrating evidence of positive clinical outcomes.[3] Aspects of performance reviewed in the ICR included sufficiency of assessments, care coordination, service planning/treatment, individual/family involvement, cultural preferences, medication management, and clinical quality outcomes.[4]

In addition to numerous AHCCCS recommendations for ADHS/DBHS enumerated in the Organizational Assessment and Structure Performance section below, the following recommendations from the CYE 2006 OFR appeared again in the OFR for CYE 2007.

- Ensure that the encounter data received from ADHS/DBHS subcontractors are timely, accurate, complete, logical, and consistent
- Ensure the completeness, accuracy, and consistency of encounter-based performance measures to ensure the integrity of information and data reported to AHCCCS
- Provide evidence that the resolution of a concern is communicated to the behavioral health recipient/guardian or originator of concern as appropriate

Additional recommendations for the PIHP related to access and quality of care include the following.

- Consider the addition of nationally standardized process measures of access that focus on the longer-term treatment process, including measures of behavioral health services utilization
- Review and update the ADHS/DBHS Technical Assistance Document, Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation, each year in keeping the AHCCCS 2007 OFR recommendation for annual review and updating of best practices guidelines

[1]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care http://www.gpoaccess.gov/cfr/index.html.*
[2]*Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.*
[3]*AHCCCS, CYE 2007 Draft Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, January 14, 2008.*
[4]*Arizona Department of Health Services, Independent Case Review 2006, June 2007*

I. BACKGROUND

A. History of Arizona's Medicaid Managed Care Programs

Medicaid is a joint federal and state program for financing medical, long term care, and additional optional services for low income legal residents of the United States. Established in 1965 under Title XIX of the Social Security Act, Medicaid's statutory requirements relating to eligibility and covered services are administered at the federal level by the Centers for Medicare & Medicaid Services (CMS). CMS has authority to waive a certain number of these requirements, on a state-by-state basis, to allow a state to structure its Medicaid program to better meet the needs of its residents, such as to offer additional services, set different eligibility criteria, or limit the choice of providers. There are a variety of Medicaid waivers available to States, with Section 1115 research and demonstration waivers allowing the most extensive departures from federally defined boundaries, such that comprehensive restructuring of health-care delivery systems along with the terms and conditions of federal funding may be approved by CMS.

Arizona's Title XIX Medicaid program was implemented in 1982 as the first statewide Medicaid managed care system in the U.S. under a Section 1115 demonstration project and is administered at the state level by the Arizona Health Care Cost Containment System (AHCCCS). This waiver has been reauthorized by CMS at five-year intervals, as required, effective to the next renewal date of October 1, 2011. Medicaid programs throughout the U.S. have increasingly moved toward prepaid capitated managed care health delivery systems in their efforts to provide health care of high quality and to simultaneously manage costs.

Medicaid managed care programs typically require members to enroll with a specific Managed Care Organization (MCO) that has a contract with the state to accept responsibility for providing and authorizing medically necessary covered services. Some state Medicaid agencies arrange for particular Medicaid-covered services, such as behavioral health care, to be "carved out" of MCO contracts and provided through a separate system, which may also be a prepaid capitated system, such as is the case in Arizona. An alternative administrative structure similar to a MCO is a Prepaid Inpatient Health Plan (PIHP). Under either an MCO or a PIHP managed care arrangement, the participating plans are paid in advance a capitated or fixed amount for each member for each month of eligibility. Thus, the plans accept a predetermined and prepaid level of funding based on the number of enrollees, and these plans agree to provide all medically necessary covered services to their members without regard to how many or how few services the members receive.

AHCCCS, serving as Arizona's Medicaid Agency, is a model public-private collaboration that involves the federal government, the state and its counties, health plans and providers from both public and private sectors, and families and individuals eligible for Medicaid services. AHCCCS contracts with health plans to deliver a comprehensive array of acute care health services to Arizona citizens who are determined eligible for Title XIX Medicaid, the majority of whom are children and pregnant women. During the contract year Arizona acute care health plans served nearly a million Arizona Medicaid Title XIX members.[1]

Eligible Native Americans have the option to receive acute care services through an AHCCCS-contracted health plan or through the Indian Health Services (IHS). AHCCCS also administers an emergency services program for persons who would otherwise quality for Medicaid, except for their immigration status. AHCCCS additionally provides capitated programs for long term care, rehabilitative services for children with chronic conditions, and a variety of other programs.

AHCCCS contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) as a PIHP to administer behavioral health services to acute Medicaid members. ADHS/DBHS was created in 1986 to serve as the Arizona State authority for coordination, planning, administration, regulation, and monitoring of all facets of the Arizona public behavioral health system. ADHS/DBHS oversees the behavioral health services available to all state-supported programs, not just Medicaid, although most recipients gain access to these programs through Medicaid eligibility.

ADHS/DBHS subcontracts with Regional Behavioral Health Authorities (RBHAs) to provide covered behavioral health services directly, or to secure a network of providers, clinics, and other appropriate facilities and services to deliver managed behavioral health services to Medicaid-eligible acute care members within the geographic service area (GSA). The RBHAs function for the provision of behavioral health services similar to how Managed Care Organizations typically function to provide medical care. Arizona's Medicaid program provides coverage for the full range of behavioral health care services, including prevention programs for children and adults and the continuum of services for adults with general mental health and substance abuse disorders, children with serious emotional disturbance, and adults with serious mental illness. Medicaid-covered behavioral health services in Arizona include outpatient treatment, rehabilitation, support, day-treatment, inpatient care, and residential services.

Arizona is divided into six GSAs served by four RBHAs for the provision of behavioral health services. During the AHCCCS contract year for 2007 (CYE 2007) covered by this report, July 1, 2006 through June 30, 2007, the four RBHAs and the counties they served were as follows.

- ValueOptions for Maricopa County
- Community Partnership of Southern Arizona (CPSA) for Pima, Graham, Greenlee, Santa Cruz, and Cochise Counties
- Northern Arizona Behavioral Health Authority (NARBHA) for Mohave, Coconino, Apache, Navajo, and Yavapai Counties
- Cenpatico Behavioral Health of Arizona (Cenpatico) for Pinal, Gila, Yuma, and La Paz Counties

In addition to the RBHAs above, ADHS/DBHS currently has Inter-governmental Agreements (IGAs) for Tribal RBHAs (TRBHAs) with five of Arizona's American Indian Tribes to provide covered behavioral health services for American Indians on reservations. Gila River Indian Community, Navajo Nation, and Pascua Yaqui Tribe of Arizona each have an IGA for both Title XIX Medicaid and State Subvention Services. Colorado River Indian Tribe has an IGA for State Subvention Services, and covered behavioral health services to other Native American Indian Tribes not identified here are through the local RBHA in which the tribal reservation is located. A CYE 2007 map showing each of Arizona's behavioral health GSAs, RBHAs, and TRBHAs is included in the Appendix.

The majority of Medicaid behavioral health services are provided on an outpatient basis. Covered services include but are not limited to behavioral management, case management, emergency/crisis services, emergency and non-emergency transportation, evaluation and screening, individual, group and family counseling, inpatient psychiatric care, partial care, psychosocial rehabilitation, psychotropic medication, respite care, and therapeutic in-home care services. Arizona also provides limited services to Title XIX Medicaid members age 21 through 64 in Institutes for Mental Diseases.

Each Arizona Medicaid member either chooses or is assigned to an acute care MCO for medical and preventive health care services. If the member requires behavioral health services, they are typically referred by their acute care plan to the appropriate T/RBHA. The member goes through the behavioral health intake evaluation process, and then receives covered behavioral health services through the T/RBHA system of contracted providers. Medicaid enrollees alternatively may self-refer directly to a T/RBHA or its contracted providers for behavioral health services.

B. Arizona's Quality Strategy Objectives, Performance Measures, Performance Improvement Requirements, and Operational System Standards for Behavioral Health Services

The Federal Balanced Budget Act of 1997 (BBA) mandated that states ensure the delivery of quality health care by all their Medicaid managed care contractors. CMS published the finalized BBA regulations (42 CFR 438 et. seq.) on June 14, 2002[2] that included specifications that each state must comply with for quality assessment and performance improvement strategies.

AHCCCS includes in its contract with ADHS/DBHS those elements that are required to monitor and measure quality, timeliness, and access to care in accordance with federal and state regulations. These elements include certain program-specific performance measures, performance improvement projects, an Operational and Financial Review (OFR) that monitors contractor compliance with federal and state laws regarding managed care systems, and periodic reports as required in the contract.

The contract between AHCCCS and ADHS/DBHS for the provision of Medicaid behavioral health services stipulates the standards for access, structure and operations, and quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM), as well as other AHCCCS policies and manuals, are incorporated by reference as a part of the ADHS/DBHS contract and provide more detailed information and requirements. The BBA requires AHCCCS to submit an annual external quality review report to CMS.[3]

AHCCCS has mechanisms to ensure that ADHS/DBHS maintains information systems that collect, analyze, integrate, and report data to achieve AHCCCS objectives. ADHS/DBHS and its subcontractors are required to have claims processing and management information systems to collect service-specific procedures and diagnosis data, encounters, and records of remittances to providers.

Data timeliness, accuracy, and completeness are assessed, and AHCCCS performs extensive data validation as a condition of its 1115 Waiver. A major source of behavioral health outcome measures is the annual Mental Health Statistics Improvement Program (MHSIP) consumer survey, which ADHS/DBHS participates in to determine consumer satisfaction related to the behavioral health system.

AHCCCS developed a formal Quality Initiative and Performance Improvement Plan in 1994 and has consistently been recognized as an innovator and national leader in the area of Medicaid Managed Care. The AHCCCS Quality Strategy specific to Medicaid Managed Care was established in 2003, and the most recent Quality Assessment and Performance Improvement Strategy Revision was published by AHCCCS in December 2007. "It is a coordinated, comprehensive, and proactive approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. It is designed to identify and document issues related to those standards, and encourage improvement through incentives, or where necessary, through corrective actions."[4]

[1]*Arizona Health Care Cost Containment System, Five-Year Strategic Plan Fiscal Year 2009-2013, January 1, 2008*
[2]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care http://www.gpoaccess.gov/cfr/index.html.*
[3]*Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations (Final Rule. Federal Register, 68(16): 3585-638), January 24, 2003.*
[4]*State of Arizona, Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007.*

II. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

The BBA requires that state Medicaid agencies provide CMS with an annual, external independent review of access to, timeliness of, and the quality outcomes of services provided by MCOs.[1] The CMS Final Rule for External Quality Review (EQR) of Medicaid Managed Care, which implemented this BBA provision, requires an annual, independent, external review of Prepaid Inpatient Health Plans.[2] ADHS/DBHS is considered by CMS to be a PIHP for the provision of Medicaid managed behavioral health services in Arizona.

The CMS Final Rule further requires that the EQR report incorporate a review of the three mandatory EQR activities consistent with the associated published protocols as follows.[3]

- Determination of MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations
- Validation of Performance Measure(s)
- Validation of Performance Improvement Project(s) (PIPs)

These EQR activities can be performed by one or more organizations, but each of these three required activities must be incorporated into a single annual report by one EQRO. For the behavioral health managed care system for Medicaid enrollees in Arizona, AHCCCS conducted the EQR activities related to documenting compliance with federal regulations and provided this Operational and Financial Review (OFR) information to the EQRO to summarize and incorporate in the Annual Report to CMS. The performance measures for EQR validation and associated goals were stipulated in the AHCCCS contract with ADHS/DBHS, and ADHS/DBHS monitored the T/RBHA's performance through Quarterly Contractor Performance Improvement Reports. ADHS/DBHS provided the EQRO (by way of AHCCCS) with copies of the quarterly reports along with a computer disc containing query language and data fields and calculations for use in the performance measure validation process. AHCCCS further stipulated, in its contract with ADHS/DBHS for administration of managed behavioral health services, that AHCCCS must review and approve required Performance Improvement Project plans and interim and final reports. AHCCCS provided ongoing technical assistance to ADHS/DBHS for complying with the CMS protocol activities and guidelines for conducting PIPs. AHCCCS gave the EQRO copies of the ADHS/DBHS PIP plans, interim reports, and related correspondence for use in the required PIP validation. No optional activities, in addition to the three mandatory activities, were included in this annual EQR report.

AHCCCS contracted with HCE QualityQuest (QQ) to produce the EQR Annual Report for behavioral health services. This report includes strengths, weaknesses, and recommendations for ADHS/DBHS. These EQRO findings and recommendations are submitted to ADHS/DBHS and CMS by AHCCCS and used to contribute to ongoing AHCCCS Quality Assessment and Performance Improvement Strategy development and the ADHS/DBHS quality improvement activities. The Arizona EQR Annual Reports are posted online on the AHCCCS Web site and thus are available for review and related use by behavioral health care recipients, Arizona stakeholders, other state Medicaid programs, and the community at large.

[1]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care http://www.gpoaccess.gov/cfr/index.html.*
[2]*Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations (Final Rule. Federal Register, 68(16): 3585-638), January 24, 2003.*
[3]*Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.*

III. ARIZONA'S STATE QUALITY INITIATIVES

The AHCCCS strategic plan goals during CYE 2007 had the following objectives.[1]

- Using nationally recognized protocols, standards of care, and benchmarks
- Using a system of rewards for physicians, in collaboration with contractors, based on clinical best practices and outcomes
- Emphasizing disease management
- Improving functionality in activities of daily living
- Planning patient care for the special needs population
- Increasing the emphasis on preventative care
- Identifying and sharing best practices
- Exploring Centers of Excellence
- Continuing to use strategic partnerships to improve access to health care services and affordable health care coverage
- Collaborating with sister agencies, contractors, and providers to educate Arizonans on health issues
- Assuring effective medical management of at-risk and vulnerable populations
- Building additional capacity in rural and underserved areas
- Collaborating on border health care issues
- Enhancing Web-based self help and health/medical information applications
- Replacing the mature AHCCCS Prepaid Medical Management Information System (PMMIS) to enhance functionality
- Enhancing the data warehouse to store data from various sources and systems to provide more robust retrieval and reporting capabilities
- Using MHSIP client satisfaction surveys to allow Arizona to continue to benchmark behavioral health outcomes with other states

These AHCCCS objectives were aligned with the Medicaid Quality Strategy developed by CMS.[2] The CMS key strategies included the following.

- Evidence-based care and quality measurement
- Payment aligned with quality
- Health information technology
- Partnerships
- Information dissemination, technical assistance, and sharing of best practices.

ADHS/DBHS' Strategic Plan 2007 directly targeted the behavioral health system in Arizona.[3] It incorporated elements of CMS' and AHCCCS' strategies toward the goal of ensuring a comprehensive, unified, and high quality behavioral health system for Arizonans. The ADHS/DBHS strategies for CYE 2007 were as follows.

- Promote recovery, resiliency, psychosocial rehabilitation, safety and hope for persons receiving services from the Arizona State Hospital, the Arizona Community Protection and Treatment Center, and the community-based behavioral health system
- Collaborate with community partners and public health in the design and delivery of behavioral health services
- Obtain and maintain a viable work force
- Enhance technology to support hospital, Arizona Community Protection and Treatment Center, and Division business

These strategies were incorporated into the annual ADHS/DBHS Quality Management and Utilization Management Plan and associated Workplan.[4] This Plan and companion work plan contained an extensive list of goals, tasks, data sources, and target dates that were the responsibility of ADHS/DBHS Quality Management Operations and other stakeholders. There is a specific Quality Management subsection in the Program Requirements Section of the AHCCCS contract with the ADHS/DBHS PIHP that contractually mandates this Quality Management Plan.[5] Numerous other Quality Management requirements in the contract include, but are not limited to, performance measures, performance improvement projects, participation in the operational review process, ensuring the completeness and accuracy of quality management data reported to AHCCCS, and investigation, analysis, tracking, and trending of quality of care issues, abuse, and/or complaints.

[1]*Arizona Health Care Cost Containment System, Strategic Plan. http://www.ahcccs.state.az.us/Publications/Strategic Planning/*
[2]*Centers for Medicare & Medicaid Services, Medicaid/SCHIP Quality Strategy. http://www.cms.hhs.gov /MedicaidSCHIPQualPrac/.*
[3]*Arizona Department of Health Services, Division of Behavioral Health Services, Strategic Plan. http://www.azdhs.gov/bhs/bh_topics.htm.*
[4]*Arizona Department of Health Services, Division of Behavioral Health Services, Quality Management and Utilization Management Plan and Work Plan. http://www.azdhs.gov/bhs/qm_plan.htm*
[5]*Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Number YH8-0002 ADHS #832007, Amendment Numbers 32, Effective January 1, 2007 except as otherwise noted.*

IV. PIHP BEST AND EMERGING PRACTICES FOR IMPROVING QUALITY OF CARE AND SERVICES

The ADHS/DBHS Web site contains links to numerous technical guidelines and protocols, which is an excellent approach to identifying and making easily available existing national standards that can be used to facilitate appropriate practice and positive outcomes.[1] A few examples of these include the following.

- Attention Deficit Hyperactivity Disorder
- Co-Occurring Psychiatric and Substance Disorders
- Children and Adolescents Who Act Out Sexually
- Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation
- The Child and Family Team
- Psychotropic Medication Use in Children, Adolescents and Young Adults
- Expert Consensus Guidelines Series

ADHS/DBHS supported the development and implementation of a Best Practices Advisory Committee that began meeting at the beginning of CYE 2007 with the goal of identifying and adopting best and promising practices in mental health, substance abuse, and prevention service. This is an emerging effort that has significant promise with continued effort and attention to recommendations in the most recent compliance review. Selected initiatives of the Best Practices Advisory Committee have been to promote Child and Family Team (CFT) expansion toward the goal of having all children served with CFTs by the end of 2008, and hiring family members and behavioral health recipients to provide peer support services.[2] Moreover, a new Practice Protocol titled Out of Home Services was developed by ADHS/DBHS. The goal was to operationalize best practices for children and adolescents who receive out of home care in residential treatment centers and behavioral health group homes.

ADHS/DBHS has worked over time to secure legislative passage of and implement a behavioral health practitioner loan repayment program. This is a tuition loan reimbursement program for behavioral health professional and technician staff who agreed to serve for two years in an Arizona mental health professional shortage area.[2]

The use of telemedicine and access to prescribers for behavioral health medications has been explored in conjunction with a RBHA network sufficiency analysis. ADHS/DBHS formalized a prescriber capacity network model that assessed both the number of child and adult prescribers per 100 enrolled behavioral health recipients and their geographic location. The model was implemented in late CYE 2006, with all RBHAs achieving compliance with minimum standards of network access and sufficiency in CYE 2007. [2]

ADHS/DBHS developed and implemented a program focusing on improving the quality and availability of suicide prevention services to youth. Best practice mental health screening programs were implemented in selected high schools and community colleges, and a core of skilled trainers was developed using Applied Suicide Intervention Skills Training. The program focused on risk assessment screening for key gatekeepers including health care professionals.

ADHS/DBHS additionally directed funding to eight Native American tribes in Arizona to develop culturally based prevention services targeting suicide, substance abuse, and methamphetamine prevention.[2]

The National Association of State Mental Health Program Directors self-assessment tool was used by ADHS/DBHS to update the Cultural Competency Plan. The ADHS/DBHS Cultural Competency Advisory Committee developed two types of cultural competency training, one pertaining to use of an organizational assessment tool within behavioral health plans and the second addressing the integration of culturally competent services into daily practice. The ADHS/DBHS 2006 Consumer Survey Report dated June 29, 2007 found that 66 percent of adult behavioral health participants statewide and 94 percent of youth survey respondents rated the services received as culturally competent. In the youth survey, questions specific to the cultural sensitivity domain produced the highest positive ratings of any category of questions. Ninety-two percent said that staff were sensitive to their cultural background, 93 percent said staff treated them with respect, and 95 percent said staff spoke with them in a way they understood.[3] Given the intensive focus on cultural competency training and services that are ongoing, it will be important to gauge the effect on consumer survey responses pertaining to cultural competency in future years.

[1]*Arizona Department of Health Services, Division of Behavioral Health Services, Technical Guidance Documents. http://www.azdhs.gov/bhs/guidance/guidance.htm*
[2]*Arizona Department of Health Services, Division of Behavioral Health Services and Arizona State Hospital Annual Report, Fiscal Year 2006, http://www.azdhs.gov/bhs/annualrpt.htm*
[3]*Arizona Department of Health Services, Division of Behavioral Health Services, Annual 2006 Consumer Survey Report, June 29, 2007. http://www.azdhs.gov/bhs/annualrpt.htm*

V. ORGANIZATIONAL ASSESSMENT AND STRUCTURE PERFORMANCE

A. Description of the Operational and Financial Review Process

ADHS/DBHS is the single managed behavioral health PIHP in Arizona. The CMS-required external review is therefore focused at the ADHS/DBHS level rather than on T/RBHAs and their providers.

An annual Operational and Financial Review (OFR) was used by AHCCCS to monitor and evaluate ADHS/DBHS compliance with Medicaid managed care federal and state regulations pertaining to behavioral health services. The CYE 2007 OFR for July 1, 2006 through June 30, 2007 was conducted by AHCCCS in October 2007. AHCCCS transmitted the draft CYE 2007 OFR report to ADHS/DBHS on January 14, 2008.[1] The AHCCCS findings related to ADHS/DBHS compliance with Federal Medicaid Managed Care Regulations incorporated in the CYE 2007 Annual EQR Report are based on the April 2008 final executive summary.

The OFR process was used for determining ADHS/DBHS compliance with Medicaid Managed Care Regulations at 42 CFR Parts 400, 430, et al., including operational and financial program compliance with its contract with AHCCCS. The AHCCCS OFR of ADHS/DBHS was consistent with the mandatory protocol for Monitoring MCOs and Prepaid Inpatient Health Plans (PIHPs),[2] as required by the CMS Final Rule on EQR of Medicaid Managed Care Organizations.[3] The OFR process was bolstered by the extensive crosswalk completed by AHCCCS to assure compliance with all federal and state regulations.

The 14 member AHCCCS OFR review team included five staff from the Behavioral Health Unit, three from the Division of Health Care Management, two from the Office of Administrative Legal Assistance, one from the Office of Legal Assistance, one from Third Party Liability, and two from the Office of Program Integrity. Twenty-nine staff from ADHS/DBHS participated in the review. The OFR tool contained 134standards/ substandards from eight domains or program areas. The program areas included General Administration, Delivery System, Recipient Services, Quality Management, Utilization Management, Finance, Appeals and Disputes, and Encounters.[1]

The OFR standards/substandards were rated based on the findings using the following thresholds.

- Full Compliance: 90 to 100% of the requirements were met
- Substantial Compliance: 80 to 89% of the requirements were met
- Partial Compliance: 70 to 79% of the requirements of the standard were met
- Non-Compliance: Less than 70% of the requirements were met

AHCCCS required ADHS/DBHS to develop a Corrective Action Plan (CAP) for most standard/substandard(s) where there were recommendations that some action must or should be taken. These CAPs are due to AHCCCS for approval within 30 days of the final OFR report.

B. Operational and Financial Review Results

Table 1, Chart1, and Chart 2 illustrate the results of the behavioral health services CYE 2007 OFR across the eight program areas reviewed.

Table 1: Behavioral Health Services CYE 2007
Operational and Financial Review (OFR) Results

Program Area	Total Number of Standards	Compliance Rating for Standard			
		Full	Substantial	Partial	Non-compliant
General Administration	19	(16) 84.2%	(0) 0%	(0) 0%	(3) 15.8%
Delivery System	9	(7) 77.8%	(1) 11.1%	(0) 0%	(1) 11.1%
Recipient Services	21	(20) 95.2%	(0) 0%	(0) 0%	(1) 4.8%
Quality Management	23	(11) 47.8%	(1) 4.3%	(3) 13.0%	(8) 34.8%
Utilization Management	11	(9) 81.8%	(1) 9.1%	(0) 0%	(1) 9.1%
Finance	9	(6) 66.7%	(1) 11.1%	(1) 11.1%	(1) 11.1%
Appeals and Disputes	30	(21) 70.0%	(2) 6.7%	(1) 3.3%	(6) 20.0%
Encounters	12	(11) 91.7%	(1) 8.3%	(0) 0%	(0) 0%
TOTAL	134	(101) 75.4%	(7) 5.2%	(5) 3.7%	(21) 15.7%

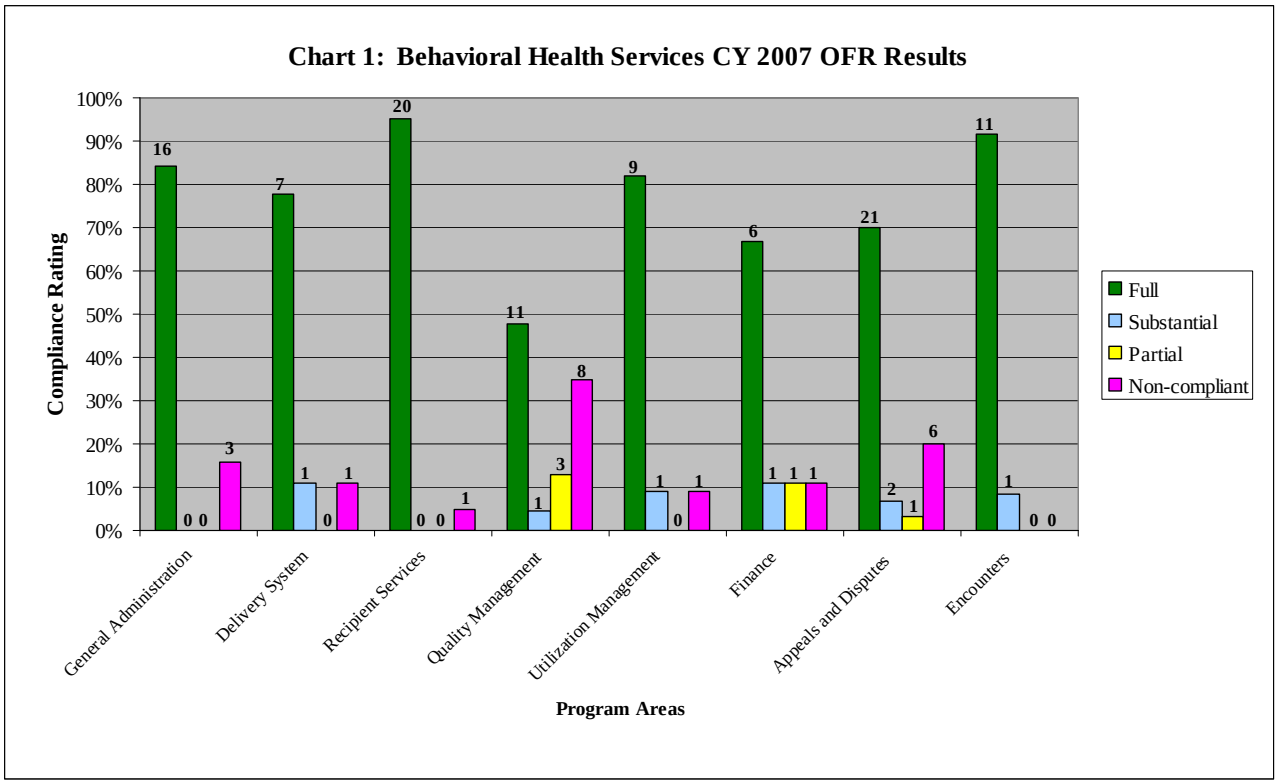


Chart 1: Behavioral Health Services CY 2007 OFR Results
Compliance Rating
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
16
0 0
3
7
1
0
1
20
0 0
1
11
1
3
8
9
1
0
1
6
1 1 1
21
2
1
6
11
1
0 0
General Administration
Delivery System
Recipient Services
Quality Management
Utilization Management
Finance
Appeals and Disputes
Encounters
Program Areas
Full
Substantial
Partial
Non-compliant

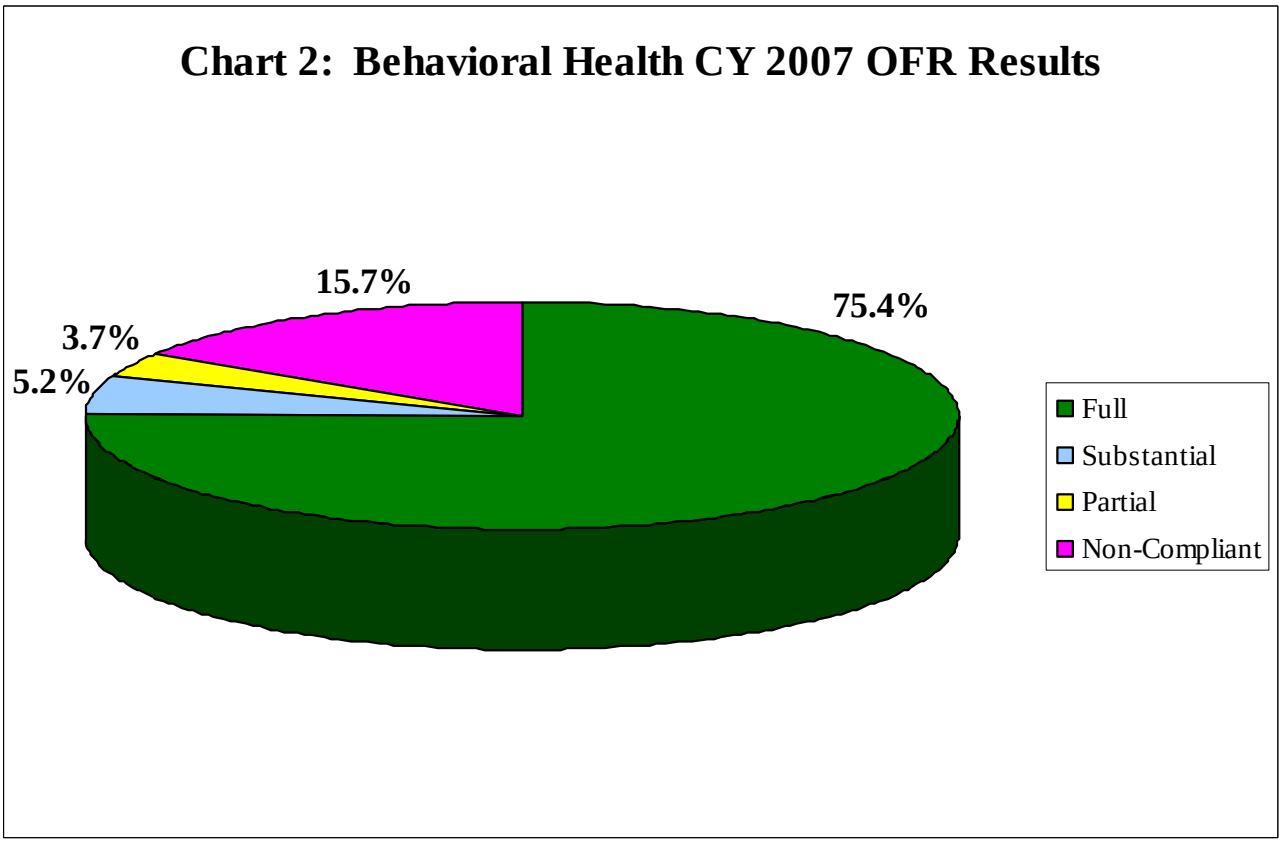


Chart 2: Behavioral Health CY 2007 OFR Results
15.7%
75.4%
3.7%
5.2%
Full
Substantial
Partial
Non-Compliant

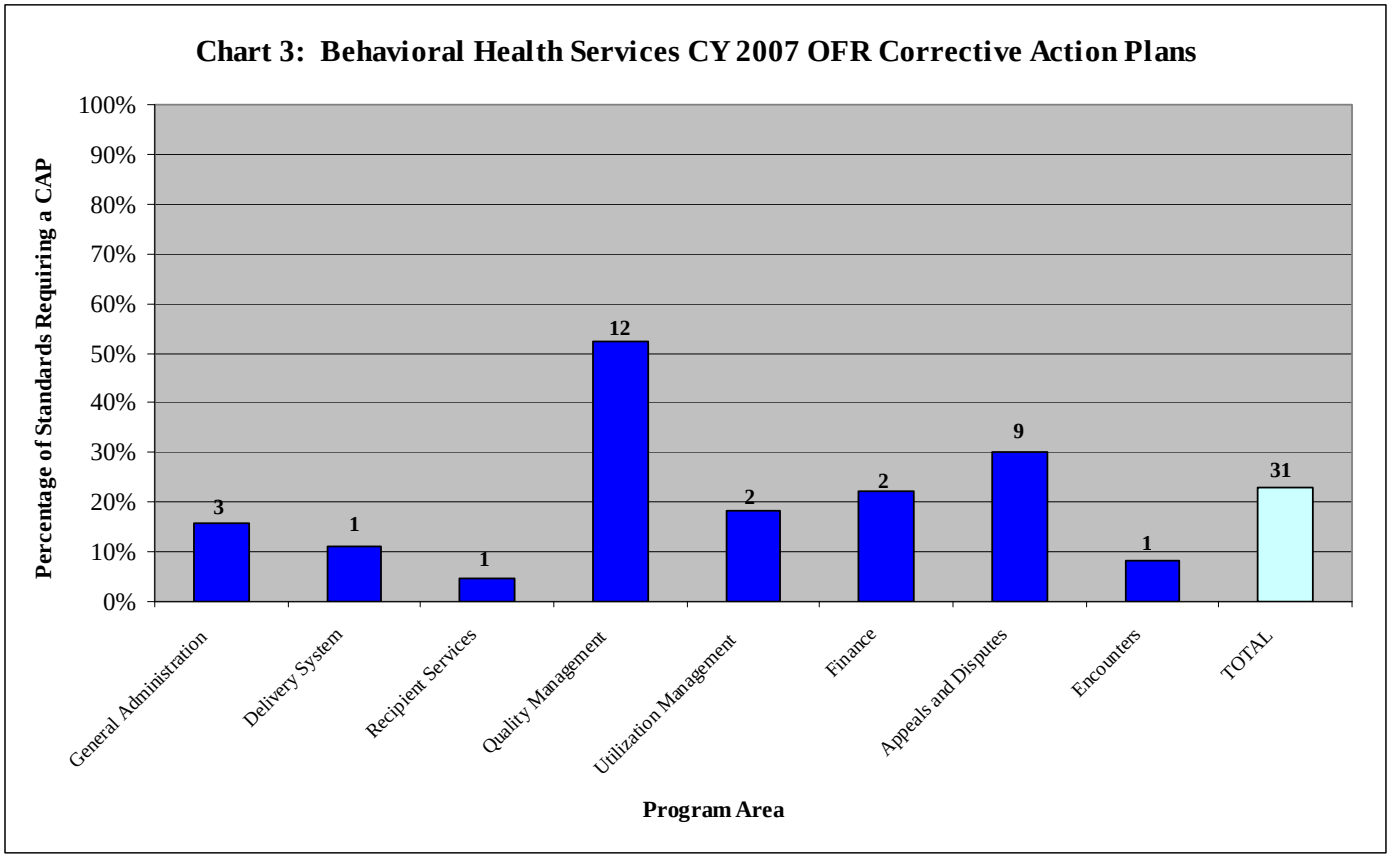
As shown in Table 1 and Chart 1 and 2, ADHS/DBHS was rated in full or substantial compliance in CYE 2007 for 101 of the 134 standards/substandards, or 75%. Seven (5%) standards/substandards received a Substantial Compliance rating, five (4%) were rated Partially Compliant. Noncompliance ratings were given in 21 (16%) instances. Eight of the 21 ratings of noncompliance were in Quality Management, one was in Utilization Management, three were in General Administration, there was one in the Delivery System, one in Recipient Services, one in Finance, and six in Appeals and Disputes area.

The number of standards/substandards receiving recommendations is shown in Table 2 across the eight OFR program areas, and the percentage of standards/substandards requiring a CAP is graphically presented in Chart 3. There were a total of 46 OFR recommendations, with a CAP needed for 31 standards/substandards, or 23.1% of the 134 total standards/substandards requiring CAPS.

Table 2: Behavioral Health Services CY 2007
Operational and Financial Review (OFR) Recommendations

Program Area	Total Number of Standards	Number of Recommendations	Number of Recommendations Requiring a CAP	Number of Standards Requiring a CAP	Percentage of Standards Requiring a CAP
General Administration	19	6	6	3	15.8%
Delivery System	9	2	2	1	11.1%
Recipient Services	21	2	2	1	4.8%
Quality Management	23	14	14	12	52.2%
Utilization Management	11	3	3	2	18.2%
Finance	9	2	2	2	22.2%
Appeals and Disputes	30	16	14	9	30.0%
Encounters	12	1	1	1	8.3%
TOTAL	134	46	44	31	23.1%

Chart 3: Behavioral Health Services CY 2007 OFR Corrective Action Plans



It is not methodologically appropriate to trend OFR performance over past years, as the number, content, and rating system of standards/substandards changed over time. For example, in CYE 2007 there were 134 standards/substandards compared to 49 in CYE 2006, and in CYE 2006 there were 54% fewer standards/substandards than in CYE 2005. No weighting system has been used to adjust the relative importance of certain standards, the program areas changed from year to year and, starting in CYE 2005, the criteria for achieving the compliance ratings were made more stringent than they were in CYE 2004 and CYE 2003.

All previous CAPs had been closed prior to conducting the CYE 2007 OFR. The CAP update submitted by ADHS/DBHS in October 2006, describing actions taken to implement all prior recommendations, was accepted by AHCCCS.

C. Strengths and Best Practices in Terms of Timeliness, Access, and Quality of Care Identified through the OFR Compliance Review

The CYE 2007 OFR standards or substandards related to timeliness where ADHS/DBHS was found to be in full compliance with federal and state regulations were as follows.

- Written policies and procedures were available that met contract requirements for appeals, state fair hearings, expedited appeal processes, and Notice of Action
- Quarterly compliance monitoring was conducted of all ADHS/DBHS' contractors' performance related to the state fair hearing process, expedited appeal process, appeal process, notification of appeal rights, Notice of Action requirements, and claim dispute process
- Emergency behavioral health services did not require a prior authorization, and what constituted an emergency medical condition was not limited on the basis of a list of diagnoses or symptoms
- Monitoring was conducted to ensure that all emergency services were provided in sufficient amount, duration, and scope to achieve the purpose for which the services were needed
- Appeal and state fair hearing requests were accepted orally or in writing
- Recipients/providers were provided with written acknowledgement of receipt of an appeal/claim dispute
- Recipient appeals, orally or in writing, were accepted up to 60 days from the date of the Notice of Action
- There was a process for communication and coordination of a recipient's benefits continuation
- There was a process for communication and coordination when an appeal or claim dispute decision was reversed
- Recipients filing appeals had a reasonable opportunity to present evidence in person and in writing and to review evidence in their case file
- Recipients had access to reasonable assistance for completing forms or navigating the grievance system
- Appeals were resolved and written notices mailed no later than 30 days after receipt of the appeal

- Notice of appeal resolutions contained all the required information
- Written notice of decision of claim disputes were sent to the provider no later than 30 days after filing of a claim dispute, and agreements to an extension of the timeframe for sending the written notice of decision were documented
- All required information was included in claim dispute notice of decisions
- Written notices regarding resolution of appeals and claim dispute decisions complied with AHCCCS standards
- Contractors were monitored to ensure that members received a written notice that explained the right to file an appeal, procedures for filing an appeal or requesting a state fair hearing or expedited appeals, and availability of assistance from the contractor in filing an appeal
- Members received a written notice that explained the member's right to have services continue, how to request continued services, and that they might be required to pay costs
- Contractors notified members and all respective parties when denying a continued inpatient stay
- Issuing and carrying out appeal decisions expeditiously was ensured

The CYE 2007 OFR standards or substandards related to access where ADHS/DBHS was found to be in full compliance with federal and state regulations were as follows.

- Contractors' provider networks were monitored to ensure that they were sufficient to provide all covered services to AHCCCS members, including availability of sufficient prescribing clinicians in all areas
- Monitoring the statewide network of subcontractors ensured that changes to or gaps in the network were reported and addressed in a timely manner
- Monitoring of contractors and subcontractors ensured that second opinions were provided to behavioral health recipients as required
- Contractors responded to requests for emergency services within 24 hours of the request as required by the contractual minimum performance standard of 85%
- Contractors offered an appointment for a routine assessment within seven days of the referral or request for behavioral health services as required by the contractual minimum performance standard of 85%
- Routine appointments for behavioral health services were scheduled within 23 days of initial assessment as required by the contractual minimum performance standard of 85%
- Cultural competency development and implementation plans ensured that behavioral health recipients received services that were compatible with their cultural and linguistic needs, and these plans were reviewed and updated annually to meet AHCCCS requirements
- Behavioral health service providers assessed and included behavioral health recipient/family cultural preferences in treatment planning as required by the contractual minimum performance standard of 80%
- All behavioral health recipient materials were translated into prevalent languages and into alternative formats

- Employees had access to and were aware of how to obtain interpretation services, and behavioral health recipients were informed of the availability of oral interpretation services

The CYE 2007 OFR standards or substandards related to quality of care where ADHS/DBHS was found to be in full compliance with federal and state regulations were as follows.

- All applicable federal and state laws on enrollee rights were complied with, all behavioral health recipients were notified of all enrollee rights annually, and processes were in place to guarantee behavioral health recipient rights when furnishing services
- Behavioral health recipients and their families were involved in the development of treatment recommendations as required by the contractual minimum performance standard of 85%
- Behavioral health recipients and/or patents/guardians were informed about and gave consent for prescribed medications as required by the minimum performance standard of 80%
- Processes were in place to guarantee behavioral health recipient rights when services were furnished
- All behavioral health recipients were notified of all enrollee rights on an annual basis, and processes were in place to guarantee recipient rights when furnishing services
- Contractors did not prohibit or restrict providers from advising or advocating on behalf of a behavioral health recipient
- Contractors were monitored to determine there was evidence of positive clinical outcomes for recipients of behavioral health services
- The timeliness, completeness, accuracy, logic, and consistency of quality and utilization management data were monitored and reported to ensure the integrity of information and data reported to AHCCCS
- Keeping confidential all behavioral health recipient information protected by federal and state law was ensured
- All required data elements necessary for quality improvement were included in the ADHS/DBHS Health Information System
- Quarterly Showing Reports related to utilization management were timely, accurate, and complete when submitted to AHCCCS
- Monitoring occurred to ensure ADHS/DBHS contractors implemented corrective action plans and demonstrated performance improvement
- Quality of care/service issues raised by behavioral health recipients, contractors, subcontractors, and other involved parties were resolved
- Performance measures for Children's System of Care were implemented
- Oversight and accountability was maintained for all functions and responsibilities described in AHCCCS Medical Policy Manual Chapter 900 that were delegated to other entities, and the entity's ability to perform was evaluated prior to delegating a function
- Quality Management analysis incident/accident data and incorporates findings into the decision making process to improve care to the behavioral health recipients.

D. Operational and Financial Review Opportunities for Improvement

Specific actions needed to address identified weaknesses related to timeliness were included in the General Administration, Utilization Management, and Appeals and Disputes program areas; those for access were in Delivery Systems and Recipient Services; and Quality concerns were primarily in the Quality Management program area but also in Recipient Services and General Administration as shown below. Each of the following CYE 2007 OFR AHCCCS recommendations for ADHS/DBHS is organized according to the eight program areas. Those that require a CAP are shown below.

General Administration

- Must provide comprehensive training to its contractors and subcontractors regarding appeal process and appeal rights
- Must have a process to evaluate staffs knowledge and familiarity with the Business Continuity and Recovery Plan.

Delivery Systems

- Ensure contractors have sufficient network capacity for Home Care Training to Home Care Client Services in all GSAs
- Ensure contractors have sufficient network capacity for counseling services in all GSAs

Recipient Services

- Monitor to determine that contractors' employees have access to references listing resources for behavioral health recipients with diverse cultural needs
- Monitor to determine its contractors provide cultural competency training for their employees on an annual basis

Quality Management

- Receive encounter data from contractors that are timely and accurate and consistent
- Be able to accurately calculate encounter-based performance measures
- Analyze and document findings of dispute and appeals data to assist in deciding what improvement activities to undertake
- Use the results of QM findings to inform decision making and improve the care of behavioral health recipients
- Document through a QM process how mortality data are reviewed and evaluated to drive decisions regarding the quality of care for behavioral health recipients
- Incorporate findings of their analysis, conclusions and actions required when reviewing the under- and over-utilization of services
- Meet the minimum performance standard of 80% in terms of having a process in place for reviewing and evaluating quality of care complaints and allegations
- Communicate acknowledgement of the concern and resolution of the concern to the originator of the concern
- Compare data trends to other available data to detect correlations
- Identify PIP topics through data collection and analysis of comprehensive aspects of its delivery system and recipient services for all of the following: (1) Topics are systematically selected and prioritized to achieve the greatest practical benefit for enrollees; (2) A minimal set of criteria is selected by considering the prevalence of a condition or need for a service by enrollees, enrollee demographic characteristics and health risks, the likelihood that the PIP will result in improved health status among enrollees and the interest of consumers in the aspect of care or services to be addressed; (3) PIPs include nonclinical and clinical focus areas that are applicable to all enrollees; and (4) Continuous data collection and analysis is stressed throughout all documents as a means of identifying appropriate study topics
- Assess statewide performance on the selected PIP indicators that incorporates all of the following: (1) Systemically assessed; (2) Includes ongoing collection; (3) Analysis of data that is accurate; (4) Collection of data that is reliable; and (5) Collection of data that is valid
- Assess all contractors' performance on the selected PIP indicators that incorporates the following components: (1) Systemically assessed; (2) Includes ongoing collection; (3) Analysis of data that are accurate; (4) Collection of data that are reliable; and (5) Collection of data that are valid
- Achieve the minimum performance standards for all Children's System of Care performance measures
- Demonstrate improvement, sustained over time, toward meeting goals for performance improvement in the Children's System of Care

Utilization Management

- Review and update practice guidelines annually
- The Best Practice Advisory committee must establish a method to annually evaluate the practice guidelines through a QM/UM multidisciplinary committee to determine if the guidelines remain applicable and represent the best practice standards and reflect current behavioral health standards. Documentation must include the review and adoption of the practice guidelines as well as the evaluation of the efficacy of the guidelines
- Adopt an inter-rater reliability plan to ensure and evaluate the consistency with which individuals involved in prior authorization decision-making apply standardized criteria for all contractors
- Ensure results are used to improve member care and services
- Ensure results are used to assess the provider facility performance

Finance

- Ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 90 days of receipt of the clean claim; clearly describe the contractual requirement in all contracts
- Comply with contractual deadlines for submitting the report analyzing current activity against significant or key assumptions used in the development of the previous year capitation rates; consider the findings from this report in the development of rates for the following year which are being developed concurrently

Appeals and Disputes

- Update files' service authorizations or payment information when an appeal or claim dispute is reversed
- Ensure that an extension was taken if extra time is required for the appeal review
- Document an extension if a decision has not been issued within the 30 (standard) or three day appeal timeframe
- Document for all extensions any notice to the recipient that an appeal resolution timeframe has been extended
- Comply immediately with assuring that all letters are in a language that is easily understood
- Monitor all contractors to ensure the timeliness of all prior authorization decisions
- Monitor all contractors to ensure that they notify the requesting provider when an "expedited" authorization request does not meet the criteria for expedited authorization
- Monitor all contractors to ensure they document when an "expedited request" is determined to be a standard authorization to clearly indicate that the decision will be made within the 14 day time frame
- Monitor all contractors to ensure they provide the member with a written notice outlining the timeframes for expedited authorization decisions
- Monitor all contractors to ensure they provide the member and provider the outcomes of the decisions (either positive or negative) within three days after an expedited request for a service is received
- Implement a process for notification of a member when an extension is required in order to make a decision on a recipient's prior authorization request
- Monitor the contractors to assure that a recipient is notified when a contractor extends the timeframe to make a prior authorization decision
- Include in this notice the right of the recipient to appeal (grieve) the decision
- Monitor contractors to assure that a recipient is notified when the contractor extends the timeframe to make a prior authorization decision and the length of that extension
- Include in this notice the right of the recipient to appeal the decision; monitor contractors to assure that the decision is made as expeditiously as possible and not later than the extension date
- Monitor contractors to ensure they provide the member with written notice that when service authorization decisions are not reached within 14 days, the authorization shall be considered denied on the date that the timeframe expires
- Monitor contractors to ensure they provide the member with written notice that for service authorization decisions not reached within 28 days, the authorization shall be considered denied on the date that the timeframe expires
- Require action from any contractors who do not provide the member with written notice within the appropriate timeframe

Encounters

- Continue efforts to ensure all encounters are submitted completely, timely, and accurately

This preceding list encompasses the CYE 2007 OFR program areas where important opportunities for improvement have been identified. Major opportunities for improvement, in areas identified in CYE 2006 OFR and again in the CYE 2007 OFR, are as follows.

- Ensure that the encounter data received from ADHS/DBHS subcontractors are timely, accurate, complete, logical, and consistent
- Ensure the completeness, accuracy, and consistency of encounter-based performance measures to ensure the integrity of information and data reported to AHCCCS
- Provide evidence that the resolution of a concern is communicated to the behavioral health recipient/guardian or originator of concern as appropriate

[1]*AHCCCS, CYE 2007 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, January 14, 2008.*
[2]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at CFR Parts 400, 430, et al, (Final Protocol, Version 1.0), February 11, 2003.*
[3]*Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations. Final Rule, (Federal Register, 68 (16): 3585-638), January 24, 2003.*

VI. PERFORMANCE MEASUREMENT PERFORMANCE

A. Background

Two access to care measures were selected by AHCCCS for validation activities comparable to the CMS protocol for performance measure validation. These two measures are as follows.

1. Appointment availability for routine behavioral health assessment within seven days of referral
2. Provision of a behavioral health service within 23 days of the behavioral health recipient's initial assessment

Validation for the first measure included the performance of RBHAs as well as Tribal RBHAs. Validation for the second measure included the performance of RBHAs only.

The quarterly Contractor Performance Improvement Activity Report/Access to Care Report was a contract deliverable for ADHS/DBHS that was due to AHCCCS each quarter, approximately 45 days after the end of the quarter. The Minimum Performance Standard was 85%, the Goal was 90%, and the Benchmark was 95% for each of these two measures of access to care.

B. Appointment Availability for Routine Behavioral Health Assessment within Seven Days of Referral

The study population was all Medicaid Title XXI/XXI eligible children and adults who were referred for a routine assessment during the measurement period. The data source for the appointment availability for routine assessment performance measure had been the paper RBHA provider referral logs through CYE 2005. Starting in CYE 2006, however, RBHAs began compiling the data electronically for submission to ADHS/DBHS. Thus, the methodology for calculating this measure was changed such that CYE 2007 calculations were based on total referral numbers rather than sample sizes. The data source was T/RBHA logs containing all Title XIX/XXI referrals for routine behavioral health services received each month during CYE 2007, July 1, 2006 through June 30, 2007. ADHS/DBHS developed strict guidelines regarding data required to be included on the monthly logs according to a specific file layout. Referral logs were sent by the T/RBHAs to ADHS/DBHS each month in comma delimited text format and placed in T/RBHA-specific folders on the ADHS/DBHS network server.

Compliance calculations of the measure included referrals identified positively as Title XIX/XXI eligible with no errors in four fields: Referral Date, First Appointment Offered Date, Program Type, and Title XIX/XXI. The referral and first appointment offered dates were used to calculate the number of days from referral to first appointment offered, with referrals to first appointment offered of less than or equal to seven days being in compliance and referrals with equal to or greater than eight days being non-compliant. Monthly data were aggregated for quarterly reporting by GSA and population (child and adult).

Field percentage of errors and total percentage of errors were calculated for all fields on the Referral Log Column Layout with the exception of Client ID. Errors were identified as erroneous or missing data in any of the other referral log fields. Error rates were not to exceed 5% per GSA per reporting quarter. If the error rate exceeded 5% for two consecutive quarters for a given T/RBHA, that T/RBHA was subject to corrective action up to and including sanctions. This was important because records with mandatory field errors were excluded from total referral numbers used to calculate performance, thereby decreasing the total number of valid referrals available to compute the measure.

ADHS/DBHS systematically reviewed T/RBHA-submitted referral logs for accuracy and completeness of the access to care data submitted. ADHS/DBHS provided technical assistance to the T/RBHAs when necessary to improve data collection methods and ensure data submitted to ADHS was valid.

From July 1, 2006 through June 30, 2007, combining data across all RBHAs, ADHS/DBHS found that 95.8% of routine assessment appointments were scheduled within seven days of referral or request for behavioral health services, achieving the benchmark standard of performance statewide for CYE 2007. The statewide quarterly compliance percentages for this measure ranged from 94.6% to 97.1%. Each and every RBHA performed at the Goal or Benchmark level each quarter, with percentages ranging from 91.8% to 98.9%, such that Benchmark performance was exceeded by individual RBHAs in the great majority of instances across all quarters of CYE 2007

ADHS/DBHS, through AHCCCS, provided each of the CYE 2007 Quarterly Contractor Performance Improvement Activity Reports as well the following data for each month of CYE 2007 for the EQRO to use in the performance measure validation process for the seven day standard.

- Referral logs as electronically submitted by each T/RBHA
- ADHS/DBHS calculation of compliance for each T/RBHA
- ADHS/DBHS calculation of errors detected on the T/RBHA submitted referral logs
- Spreadsheet designed to aggregate T/RBHA monthly performance for quarterly reporting
- Text version of the programming used by ADHS/DBHS to calculate compliance and error rates related to the seven day standard
- Visual Basic format programming used by ADHS/DBHS to calculate compliance and error rates related to the seven day standard

The EQRO examined a number of fields for errors using the methodology described for calculating the days from referral to appointment offered. The fields validated to verify data calculations in order to arrive at reportable numbers included referral date, first appointment offered date, Title XIX/XXI enrollment, and program type for determining child and adult population groups. All four of the above fields/variables had to have been error free in order for a case to be included in the analysis. A frequency count was then conducted in an attempt to reproduce the ADHS/DBHS reported data on this performance measure.

The ADHS/DBHS statewide compliance percentages from quarter to quarter ranged from 94.6% to 97.1%. The EQRO repeated the ADHS/DBHS calculations as a part of performance measure validation, as shown in Table 3, finding an identical percentage as had been reported by ADHS/DBHS of 95.8% of routine assessment appointments having been scheduled within seven days of initial assessment during CYE 2007, exceeding the Benchmark Performance Standard statewide. The ADHS/DBHS statewide compliance percentages ranged across quarters from 94.6% to 97.1%, and the EQRO-calculated quarterly percentages similarly ranged from 94.7% to 97.0%, in no case varying from each other by as much as 5%.

Table 3: Routine Appointment for Initial Assessment Within 7 Days of Referral
Statewide RBHAs Title XIX/XXI

Quarter 1 CY 2007 July 1 - September 30, 2006			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
14,057	97.1%	14,377	97.0%
Quarter 2 CY 2007 October 1 - December 31, 2006			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
12,953	94.6%	13,213	94.7%
Quarter 3 CY 2007 January 1 - March 31, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
14,059	96.7%	14,297	96.7%
Quarter 4 CY 2007 April 1 - June 30, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
14,962	94.7%	15,177	94.7%
TOTAL CY 2007 July 1, 2006 - June 30, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS CY 2007 Percentage Compliance**	**EQRO Validated Referrals**	**EQRO CY 2007 Percentage Compliance**
56,031	95.8%	57,064	95.8%

Combined ADHS/DBHS data for the Gila River and Pascua Yaqui Tribal RBHAs from July 1, 2006 through June 30, 2007, as shown in Table 4, indicated that 87.1% of routine assessment appointments were scheduled within seven days of referral, which exceeded the Minimum Performance Standard for this measure. According to the ADHS/DBHS quarterly reports, the T/RBHAs performance on the seven day standard improved over the year, starting at 70.6% in the first quarter, 93.4% in the second quarter, 91.8% in the third quarter, and 97.2 percent in the fourth quarter. The EQRO-calculated results differed slightly, but in no instance varied more than 5%, from these ADHS/DBHS results. The EQRO calculations found 87.1% of T/RBHA routine assessment appointments were scheduled within seven days of initial assessment, with percentages of 69.2% for the first quarter, 91.8% for the second quarter, 97.3 % for the third quarter, and 97.8% for the fourth quarter.

Table 4: Routine Appointment for Initial Assessment Within 7 Days of Referral

Statewide Tribal RBHAs Title XIX/XXI

Quarter 1 CY 2007 July 1 - September 30, 2006			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
163	70.6%	240	69.2%
Quarter 2 CY 2007 October 1 - December 31, 2006			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
183	93.4%	268	91.8%
Quarter 3 CY 2007 January 1 - March 31, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
207	91.8%	307	87.3%
Quarter 4 CY 2007 April 1 - June 30, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS Quarterly Percentage Compliance**	**EQRO Validated Referrals**	**EQRO Quarterly Percentage Compliance**
180	97.2%	275	97.8%
TOTAL CY 2007 July 1, 2006 - June 30, 2007			
ADHS/DBHS Total Referrals	**ADHS/DBHS CY 2007 Percentage Compliance**	**EQRO Validated Referrals**	**EQRO CY 2007 Percentage Compliance**
733	88.8%	1,090	87.1%

C. Provision of a Behavioral Health Service within 23 Days of the Behavioral Health Recipient's Initial Assessment

The study population was all Medicaid Title XIX/XXI eligible children and adults with a behavioral health intake date during the reporting period. The data source was electronic snapshot data from the Client Information System (CIS)/Electronic Data System Intake table/Disenrollment table, Snapshot encounter table. The assessment date was obtained from encounter data, with a list of codes provided for use in identifying an assessment. For inclusion in this performance measure, the assessment must have occurred within 45 days of the intake date. Thus, usable data were those for behavioral health recipients with an intake date during the study period with a corresponding assessment encounter that must have occurred within 45 days of the intake date. Data were unusable for behavioral health recipients with an intake date during the reporting period but no corresponding assessment encounter data or when the assessment occurred more than 45 days after the intake date. Reporting frequency was quarterly, with a 3-month lag time applied to accommodate submission of encounters to the Client Information System.

An assessment was defined as the ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder existed, if there was a need for behavioral health services, and ensure on an ongoing basis that the person's service plan was designed to meet the person's (and family's) current needs and long-term goals.

An encounter was defined as a record of a service rendered by a registered AHCCCS provider to an AHCCCS behavioral health recipient enrolled with a capitated contractor on the date of service. RBHAs had 210 days to submit encounter data to ADHS/DBHS and 120 days to process pending encounter data. Lag time allowed for the provider to submit encounter data to the RBHA and, in turn, for the RBHA to submit the data to ADHS/DBHS.

An intake was defined as the collection by appropriately trained RBHA/Provider staff of basic demographic information about a person in order to enroll him/her in the ADHS/DBHS system, to screen for Title XIX/XXI AHCCCS eligibility, and to determine the need for any co-payments.

First service was defined by a group of included/excluded procedure codes obtained from the encounter data. There were limitations on the type of billable service rendered within 23 days of assessment that qualified as a first service. A specified list of behavioral health service categories were excluded as a first service if they occurred on the same day as the assessment. Behavioral health recipients could have received any covered service on the same day as the initial assessment, but only included services were considered in calculating the performance measure. An assessment provided a minimum of one day after the initial assessment met the requirements to qualify as a first service.

Calculation of this measure involved the following steps.

1. ADHS received the behavioral health recipient enrollment data from the RBHAs by the snapshot CIS/EDS Intake/Disenrollment tables
2. The minimum encounter data submission requirements and minimum performance standards for usable data were applied
3. The percentage of Usable Enrollments was calculated

   - Numerator: Number of Usable Enrollments
   - Denominator: Total number of Enrollments

4. The percentage compliant with providing a service within 23 days of assessment was calculated

   - Numerator: Number of behavioral health recipients with an intake date during the reporting period with a corresponding assessment encounter within 45 days of the intake date and with an ongoing service encounter within 23 days of the assessment
   - Denominator: Total number of behavioral health recipients with an intake date during the reporting period with a corresponding assessment encounter within 45 days of the intake date

The accuracy and completeness of data submitted by the RBHAs to the ADHS/DBHS Client Information System was ensured through pre-processor edits and random data validation review of behavioral health recipient medical charts. In the event that the prevalence of unusable data (intakes without an assessment encounter within 45 days of intake date) prevented assessment of compliance with this performance measure, ADHS/DBHS could require documentation from chart audits to substantiate the provision of service.

This performance measure was calculated for each reporting quarter 30 days after the end of the subsequent quarter, allowing a 90-day lag time for encounter submission (e.g., April - June 2007 quarter was calculated in November 2007). Compliance was calculated on cumulative performance for the current reporting quarter and rerun of the previous three quarters to capture additional encounter submissions. Data were reported by GSA and population (child, adult).

Aggregated data for CYE 2007, using refreshed data as of December 31, 2007, showed 74.04% of enrollments were usable for calculation of this measure, exceeding the 65% minimum performance standard. Of these, 87.91% of the total statewide usable cases received behavioral health services within 23 days of initial assessment. This result exceeded the Minimum Performance Standard of 85%. This was based on a total statewide number of usable cases of 46,643, of which 29,831 were adults and 16,812 were children. For adults, 89.80%, approaching the Goal of 90%, received behavioral health services within the 23 day standard, while this rate for children was 84.75%, just short of the Minimum Performance Standard of 85%.

ADHS/DBHS, through AHCCCS, provided the EQRO with the following to use in the performance measure validation process.

- Databases, queries, and resulting tables used to calculate performance for each CYE 2007 quarter as stated in the Quarter 2, 2008 Quarterly Contractors Performance Improvement Activity Report. The source tables in each database originated from data available in CIS at the time of quarterly snapshots
- Text file of the SQL script used to pull encounters from CIS for the 23 day standard
- A copy of the Quarterly Contractors Performance Improvement Activity Report submitted to AHCCCS on January 30, 2008, including the access to care standards and the most recently reported aggregated CYE 2007 performance on the 23 day standard

The source data tables were not provided, limiting the analyses and data validation procedures conducted, including inclusion/exclusion criteria and usable/unusable cases. Using the information available as listed above, the following variables or fields were examined by the EQRO to verify data collection and arrive at reportable numbers.

- Enrollment date per quarter
- Title XIX/XXI enrollment
- Adult/Child status
- Qualifying behavioral health services occurring within 23 days of initial assessment

Table 5 displays the aggregated statewide data reported by ADHS/DBHS based on 12/31/2007 Snap Encounter data, compared to recalculations performed by the EQRO using the data tables enumerated above.

Table 5: Routine Assessments for Ongoing Services Within 23 Days of Initial Assessment
Quarter 1 through Quarter 4, CY 2007
Dates of Enrollment Reported for July 1, 2006 through June 30, 2007
Title XIX/XXI Only

Total Enrollments	Total Usable Enrollments	Percentage of Usable Enrollments	Of Usable Cases - The Number Within 23 Days	Of Usable Cases - The Percentage Within 23 Days
Aggregate Statewide Results for All Populations				
ADHS/DBHS				
71,660	53,055	74.04%	46,643	87.91%
EQRO				
71,660	53,055	74.04%	46,023	86.75%
Aggregate Statewide Results for Adults				
ADHS/DBHS				
47,131	33,218	70.48%	29,831	89.80%
EQRO				
47,131	33,218	70.48%	29,063	87.49%
Aggregate Statewide Results for Children				
ADHS/DBHS				
24,529	19,837	80.87%	16,812	84.75%
EQRO				
24,529	19,837	80.87%	16,960	85.50%

As shown in Table 5, the EQRO calculations produced the same or similar results, differing by no more than 5% from the comparable ADHS/DBHS calculations, which is within acceptable limits of variation or margin of error for validation purposes. Moreover, the slight differences in EQRO findings suggested that each of the adult and child population groups exceeded the 85% minimum performance standard for this measure, as did the total statewide percentage of usable cases receiving behavioral health services within 23 days of initial assessment.

VII. PERFORMANCE IMPROVEMENT PROJECT PERFORMANCE

The CMS protocols for use in conducting Medicaid External Quality Review Activities include one titled Conducting Performance Improvement Projects and another titled Validating Performance Improvement Projects.[1,2] According to these protocols, "The purpose of health care quality performance improvement projects (PIPs) is to assess and improve processes, and thereby outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner." The protocols describe ten activities to be undertaken when conducting PIPs as follows, along with extensive additional explanatory text.

1. Select the study topic(s) to target improvement in relevant areas of clinical care and non-clinical services. Topics selected for study must reflect the Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease, should affect a signification portion of the enrollees (or a specified sub-portion of enrollees) and have a potentially significant impact on enrollee health, functional status, or satisfaction
2. Define the study question(s), which must be stated as clear, simple, objectively answerable question(s)
3. Select the study indicator(s) or performance measure(s), which must be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.
4. Use a representative study population generalizable to the entire Medicaid enrolled population to which the PIP study indicator(s) apply
5. Review data for the entire study population when electronic source data are available, eliminating the need to ascertain that samples are representative of the identified population; however, if sampling must be used, sound techniques are essential
6. Collect data on the PIP indicators that are valid and reliable
7. After determining baseline levels of the performance indicator(s), develop and implement system interventions and improvement strategies designed to change behavior
8. Analyze data and interpret study results according to the data analysis plan
9. Plan for "real" improvement by determining the extent to which any changes in performance indicator(s) are statistically significant
10. Achieve sustained improvement demonstrated through repeated measurements of the performance indicator(s) over comparable time periods

Mandatory PIP validation activities are assessing the study methodology and evaluating overall validity and reliability of PIP results.[2] AHCCCS approved the "Psychotropic Medication Polypharmacy" PIP proposal from ADHS/DBHS on December 1, 2004 to begin in CYE 2005. Research was cited suggesting that prescribing multiple psychiatric medications did not always increase the efficacy, instead frequently increasing the risk to the client and the costs to the system. ADHS/DBHS defined the study topic, inappropriate polypharmacy, as the use of two or more psychotropic medications within the same class at the same time, other than for cross-tapering purposes without specific rationale; and, the use of three or more psychotropic medications from different classes at the same time without a specific rationale for the combination of medications utilized in the overall treatment of behavioral health disorders.

Data from the 2003 Independent Case Review found that, for clients who were prescribed three or more psychotropic medications, rationale for combined use was documented in the medical record for 32.6% of the adult cases reviewed and 33.3% of children's cases reviewed. For clients who were prescribed four or more psychotropic medications, rationale for combined use was present in 26.1% of the adult cases and 37.5% of the children's cases reviewed. These data were construed as providing an opportunity for improvement.

The study question was "Will educational efforts targeted toward prescribing clinicians who are identified as utilizing prescribing patterns that involve inappropriate polypharmacy result in an increase in the appropriate use of polypharmacy as measured by the number of medical records that contain rationale for its use?"

Two performance indicators, categorized by RBHA and stratified by child and adult, were proposed as follows.

1. Number and percent of members whose medical record contains documentation of rationale for the use of more than two (note: equivalent to three or more) psychotropic medications within the same class for over 60 days. (Source: Independent Case Review; Goal: Increase 5% per year)

   - Numerator: Number of member records that contain rationale for the use of more than two (2) psychotropic medications within the same class
   - Denominator: Number of member records that indicate the member is receiving more than 2 psychotropic medications within the same class for over 60 days

2. Number and percent of members whose medical records contain rationale for the use of more than three (note: equivalent to four or more) psychotropic medications within different classes for over 60 days. (Source: Independent Case Review; Goal: Increase 5% per year)

   - Numerator: Number of medical records that contain rationale for the use of more than three psychotropic medications within different classes
   - Denominator: Number of medical records that contain rationale for the use of more than three psychotropic medications within different classes

The study population included all Title XIX/XXI eligible children and adults who were enrolled in the Arizona behavioral health system and who were currently receiving more than two psychotropic medications within the same class or more than three psychotropic medications from different classes at the same time.

The study period was annual with the measurement period continuing for four years. Data were collected using the Independent Case Review process and pharmacy reports generated by the RBHAs. An independent contractor performed Independent Case Review chart reviews for these and several other measures according to a pre-determined protocol. The sample was to be extracted using simple random sampling methodology, and it was noted that a subset of the Independent Case Review sample cases would be used for the Psychotropic Medication Polypharmacy PIP. Performance measures were to be analyzed and reported annually. Data were to be stratified by RBHA and by children and adults. Individual RBHA performance was to be analyzed and compared to statewide averages for each of the two indicators.

ADHS/DBHS provided an interim Psychotropic Medication Polypharmacy PIP to AHCCCS dated September 15, 2005. The PIP workgroup drafted a technical assistance document titled "Polypharmacy" to be used as the PIP educational intervention. Standards for each of the indicators were as follows. The Minimum Standard was 60%, the Goal was 65%, and the Benchmark was 70%. No explanation was provided for why these standards and goals differed from those established in the original PIP proposal. One limitation of the baseline data noted was that the sample sizes pertinent to polypharmacy available through the Independent Case Review were quite small, as only 4.3% of the total sample of adults and 0.7% of the children were prescribed three or more psychotropic medications. Only 16.8% of the total sample of adults and 4.4% of the children were prescribed four or more psychotropic medications simultaneously. No solution was proposed to deal with the extremely small sample sizes. The 9/15/05 Interim Report proposed implementing the statewide intervention of the Polypharmacy Technical Assistance Document on 12/15/05, with the Independent Case Review chart reviews for 2005 to occur January through April 2006.

Between the time when the original Psychotropic Medication Polypharmacy PIP proposal was approved and the time when the PIP Interim Report was received, changes had occurred at AHCCCS in terms of the staff responsible for PIP oversight and approval. AHCCCS sent a detailed letter to ADHS/DBHS on October 31, 2005 in response to the Polypharmacy PIP Interim Report, outlining numerous questions, concerns, and requests for additional information. A Program Improvement Project Matrix accompanied this letter from AHCCCS, outlining the required PIP steps or activities and reference documents, statements of PIP requirements and whether they were present and the page if applicable, and extensive comments. AHCCCS evaluated the overall validity and reliability of the Psychotropic Medication Polypharmacy PIP results as having low confidence in the results and requesting modifications.

No documentation was provided to the EQRO that ADHS/DBHS ever responded to the October 31, 2005 AHCCCS request for PIP modifications, a time period when AHCCCS was undergoing a reorganization between of its behavioral health unit and acute operations. An AHCCCS letter to ADHS/DBHS dated August 30, 2007 provided a reminder that a Psychotropic Medication Polypharmacy PIP Interim Report was due to AHCCCS on 09/15/2007 and expressed concern about the viability of the project and requested specified items be addressed, including identifying the data collection method since the Independent Case Review data collection and analysis by an independent contractor was no longer an option. A Psychotropic Medication Polypharmacy PIP Interim Report from ADHS/DBHS dated September 15, 2007 was received by AHCCCS. This 09/15/2007 report stated that improvement was gained in Year Three of the PIP, but the findings were still below the minimum benchmark of 60% for three of the four sampled areas. ADHS/DBHS suggested this indicated a need for more intensive training and targeting of specific providers and service locations for focused improvement activities. The 09/15/2007 Interim PIP Report proposed, for Year Four of the project, that instead of using the Independent Case Review tool, the collection of data would involve a larger sample provided by the RBHAs and validated by pharmacy encounter data.

AHCCCS followed up by creating a technical assistance tool to guide the principles of PIPs as they relate to the Psychotropic Medication PIP as well as for future PIPs and held a meeting with ADHS/DBHS Quality Management staff on October 10, 2007. AHCCS also participated in a discussion of the Polypharmacy PIP at the October 12, 2007 RBHA Medical Directors meeting and reviewed the 09/15/2007 Interim Report through a letter dated October 23, 2007. In summary, AHCCCS agreed that using pharmacy data and focus reviews for the final year of this PIP had potential to yield more accurate data to access the effectiveness of interventions and identify negative outcomes, if any, as a result of inappropriate use of polypharmacy. AHCCCS discussed with ADHS/DBHS that the PIP, as originally proposed, did not include Arizona Medicaid data showing that psychotropic medication polypharmacy issues resulted in adverse outcomes or had negative outcomes in members' functional status. Although polypharmacy may have had negative effects, the fact that the PIP was not originally constructed to demonstrate this made it impossible for AHCCCS to evaluate if the PIP has face validity for sustained improvement. ADHS/DBHS was notified that AHCCCS, as a result, would not require a continuation of this specific PIP.

The EQRO review of the Psychotropic Medication Polypharmacy PIP supported the issues previously identified by AHCCCS as problems and concurred with the AHCCCS decision that validation of this PIP produced low confidence in the reported results. There were one or more problems identified for each of the ten activities to be undertaken when conducting a PIP, as outlined previously according to the CMS protocol.[1] In summary, the Psychotropic Medication Polypharmacy study topic may potentially have had a significant impact on enrollee health, functional status, or satisfaction, but this was never specifically demonstrated, and statistical significance within the study was not discussed or presented. The study question could not be credibly answered because of study design and data collection issues. The study indicators were not clearly aligned with the data collection tool, for example one study indicator specifying "two or more" while the data collection tool specified "three or more" and the second study indicator specified "three or more" while the data collection tool specified "four or more."

One of the more serious issues was the extent to which the size of the study population who received inappropriate psychotropic medication polypharmacy was never adequately defined. The Independent Case Review process used to define the extent of the problem was designed to select a sample and review medical records for a whole host of indicators, not just those for the PIP study indicators. The random sample used produced a very small number of cases that fit the definition of the psychotropic medication polypharmacy denominators, and this rendered the data collection, analysis, and determination of statistical significance of any improvement as a result of the intervention impossible. Certainly, with such small denominators, proposed stratification by RBHA and age were infeasible. Thus, the sampling and data collection and analysis plans were inextricably flawed, and these were critical issues that rendered the reported results as having low confidence or not being credible.

Still, there are several potential benefits of activities related to this PIP. First, AHCCCS has approved ADHS/DBHS to use pharmacy data and focused reviews for the PIP final year, and this provides an opportunity to more accurately identify the size of the population meeting inappropriate psychotropic medication polypharmacy definitions as well as identifying negative outcomes, if any, as a result of such polypharmacy. This ordinarily would have occurred in the first year of the PIP, and remains important information to determine now. Second, the development and distribution of the Technical Assistant Document #9 Desktop Guide titled Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation was a strength. It is valuable for documenting ADHS/DBHS best practice recommendations and educating providers, including defining and listing psychotropic medications within the same class and from different classes. Third, ADHS/DBHS has, in the process of conducting this PIP, received considerable technical assistance from AHCCCS, including a matrix outlining PIP requirements and references. There should be many opportunities to benefit from this technical assistance and use the matrix in the future as a guide for designing and conducting PIPs in general.

[1] *Conducting Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002.*

[2] *Validating Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002.*

VIII. CONCLUSIONS AND RECOMMENDATIONS FOR THE BEHAVIORAL HEALTH PIHP

In the CYE 2007 AHCCCS OFR designed to monitor compliance with federal and state Medicaid Managed Care PIHPs, ADHS/DBHS was rated in full or substantial compliance for 101 of the 134 standards/substandards, or 75%. Seven (5%) substandards received a Substantial Compliance rating, and five (4%) received a Partial Compliance rating. Non-compliance ratings were given in 21 (16%) instances. Eight of the 21 ratings of noncompliance were in Quality Management, three were in General Administration, one was in Utilization Management, one was in the Delivery System program, one in Recipient Services, one in Finance, and six in Appeals and Disputes area.

A CAP was required in each of the 31 instances where recommendations were documented in the OFR, or 23.1% of the 134 total standards/substandards. The complete list of the recommendations requiring CAPS from the ADHS/DBHS PIHP is included in the section titled OFR-Identified Opportunities for Improvement above. Specific actions needed to address identified weaknesses related to timeliness were shown in the General Administration, Utilization Management, and Appeals and Disputes program areas; those for access were in Delivery Systems and Recipient Services; and quality concerns were primarily in the Quality Management program area but also in Recipient Services and General Administration program areas.

Recommendations from the CYE 2006 OFR that appeared again in the CYE 2007 OFR, indicating they continue to need to be addressed, are as follows.

- Ensure that the encounter data received from ADHS/DBHS subcontractors are timely, accurate, complete, logical, and consistent
- Ensure the completeness, accuracy, and consistency of encounter-based performance measures to ensure the integrity of information and data reported to AHCCCS
- Provide evidence that the resolution of a concern is communicated to the behavioral health recipient/guardian or originator of concern as appropriate

ADHS/DBHS submitted Corrective Action Plans for AHCCCS approval within the required timeframe that addressed all OFR recommendations included in the CYE 2006 EQRO Annual Report. The CAP update submitted by ADHS/DBHS in October 2006 described actions taken to implement all prior recommendations and was accepted by AHCCCS. All previous CAPs were closed prior to conducting the CYE 2007 OFR.

For all RBHAs combined statewide, the Access to Care/Appointment Availability performance measure showed 95.8% of routine appointments for initial behavioral health assessments were scheduled within seven days of referral, which exceeded the Benchmark Performance Standard for CYE 2007 as a whole, and exceeded either the Goal or Benchmark in each of the four quarters of the year. Similar results were found by the EQRO as a part of performance measure validation activities. Performance on this measure has been at Benchmark levels for the last two years. It was 95.5% in CYE 2006 based on data from samples, compared to 95.8% in CYE 2007, which was the first year that all data were electronic and calculated for the entire population of referrals rather than using samples.

For the Gila River and Pascua Yaqui Tribal RBHAs combined, the percentages of appointments scheduled for initial assessments within seven days of referral for the first quarter of CYE 2007 through the fourth quarter were 70.6%, 93.4%, 91.8%, and 97.2%, or 88.8% for the entire year, which exceeded the Goal Performance Standard. The EQRO-calculated percentages differed somewhat from the ADHS/DBHS results, but in no case was there more than a 5% variance. The EQRO result for the year of 87.1% also exceeded the Goal.

For the second Access to Care/Appointment Availability performance measure, ADHS/DBHS reported that 87.91% of the total statewide usable cases received behavioral health care services within 23 days of initial assessment, exceeding the Minimum Performance Standard of 85%, and EQRO calculations found similar results.

The two Access to Care/Appointment Availability performance measures address different aspects of access. Both the 7 day standard and the 23 day standard were useful for assessing the sufficiency of the provider network, and the 23 day standard provided a measure of the actual receipt of behavioral health services rather than just the availability of an appointment. Both measures, however, address access from the vantage point of new clients seeking initial behavioral health services rather than clients farther along in their treatment plans. The CYE 2006 ADHS/DBHS Consumer Survey Report found 75% of adults statewide and 75% of children or their family members reported positively about service access, suggesting a need for improvement in service access more than the findings related to the two Access to Care performance measures validated in CYE 2007 might suggest. A recommendation to the PIHP is that additional nationally standardized process measures of access should be considered that focus on access during the longer-term treatment process, including measures of utilization.

The Psychotropic Medication Polypharmacy PIP selected for validation in CYE 2007 was found to be methodically flawed across several of the required PIP activities, such that conclusions could not be drawn about the extent of the study problem or any effect it had on treatment outcomes, the size of the affected population, or the statistical significance of observed improvements in documentation in charts justifying prescribing multiple psychotropic medications simultaneously. Nevertheless, inappropriate polypharmacy is a potential quality concern, and the future activities proposed for this PIP should better define any problem in this area, if there is a problem. Specific recommendations for ADHS/DBHS related to this PIP are as follows.

- Review and update the ADHS/DBHS Technical Assistance Document, Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation, each year in keeping the AHCCCS 2007 OFR recommendation for annual review and updating of best practices guidelines
- Reassess whether there is a polypharmacy problem and the extent of any associated negative effects on treatment outcomes based on analysis of pharmacy data and focused reviews conducted in Year Four
- Use the AHCCCS Program Improvement Project Matrix and the CMS protocol for Conducting Performance Improvement Projects to provide technical assistance and guidance in designing and conducting PIPs

ADHS/DBHS effectively addressed the recommendations for quality improvement made during the previous year's EQR by continuing the development and improvement of a system supporting the collection, analysis, and reporting of electronic appointment availability for routine assessment data from the RBHAs to ADHS/DBHS. This uniform system of data collection and evaluation is expected to greatly improve the timeliness, accuracy, and quality of data. Increasing the number of routinely collected measures that can be calculated solely using electronic data decreases the cost and data quality issues associated with medical record abstraction. Moreover, concerns about the representativeness of samples are avoided when the entire universe of participants can easily be included in the analysis of electronic data.

APPENDIX
ADHS/DBHS Behavioral Health Services
CYE 2007
Map of GSAs and T/RBHAs